

# Kansas Medical Assistance Programs



*From the office of the Fiscal Agent*

Provider Line: 1-800-933-6593  
Consumer Line: 1-800-766-9012  
Pharmacy Help Desk: 1-866-405-5200

P.O. Box 3571, Topeka KS 66601-3571  
Prior Authorization: 1-800-285-4978 or 785-274-5499  
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

## Adalimumab (Humira®) Prior Authorization Request Form

Consumer Name: \_\_\_\_\_

Consumer Medicaid ID #: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Provider Medicaid ID#: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Drug Name: \_\_\_\_\_ NDC Requested: \_\_\_\_\_

**- OR -**

Prescribing Physicians Name: \_\_\_\_\_ Provider Medicaid ID#: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

J-Code requesting: \_\_\_\_\_ # of units requesting: \_\_\_\_\_

1. Please indicate the diagnosis and severity for which Humira is being prescribed (no dx codes):  
\_\_\_\_\_

2. Prescribed by a Rheumatologist? Yes ☐ No ☐

3. Documentation of inadequate response to one or more DMARD's (Disease Modifying Antirheumatic Drugs) such as methotrexate, hydroxychloroquine, sulfasalazine, or gold salts:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. TB skin test results: Date: \_\_\_\_\_ Positive ☐ Negative ☐

Prescribing Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.**

**This form will be returned unprocessed if it is not completed in its entirety.**

**If a case has been started and the information requested is not received within 15 working days, the case will be denied.**